

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-047522

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 100

FILED DEC 18 1962

VS 300
Rev. 4/59

6542

2540

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95411

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12-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Length of stay in 1b <u>15 yrs.</u>	c. CITY OR TOWN <u>Lexington</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>R. #1</u> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Everett</u> Last <u>Allison</u>		4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-1908</u>
9. AGE (last birthday) <u>59</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>15</u>	IF UNDER 24 HR Hours <u>36</u> Min. <u>hrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lubricator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lake City Arsenal</u>	
11. BIRTHPLACE (City and state or country) <u>Higginsville, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Noah Allison</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Sharp</u>	
14. NAME OF HUSBAND OR WIFE <u>none</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT <u>Charles H. Allison</u> Address <u>Excelsior Springs</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>due to duodenal ulcer (ruptured about 6:00 PM)</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Nephrosis</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour = _____ a.m. _____ p.m. Month, Day, Year _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____	
21. I attended the deceased from <u>1:14, 61</u> to <u>12:57, 62</u> and last saw her/him alive on <u>Dec. 6, 1962</u> Death occurred at <u>11:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>Dr. W. Ward</u> (Degree or title) 22b. ADDRESS <u>Lexington, Missouri</u> 22c. DATE SIGNED <u>12, 8, 62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>12-8-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City</u>	23d. LOCATION (City, town, or county) (State) <u>Higginsville, Missouri</u>
24. FUNERAL DIRECTOR <u>Forrest A. Hoefer</u>	ADDRESS <u>Higginsville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-8-62</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

DEC 20 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Forrest R. Hoefler

Licensed Embalmer No. 4801

P. O. Address Higginsville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.